(Sample only—revise language or content to reflect the understanding and circumstances of the person signing.)

## POWER OF ATTORNEY FOR MEDICAL TREATMENT DECISIONS

I am ______________________. I live at ____________________________________. I want _________________________ to help me if I am sick and if I need to go to the doctor.

My mother/father read this paper to me before I signed it. I understand what he/she told me about this paper before I signed it.

If I am sick, my mother/father should take me to the doctor. If she/he is not at my house when I become sick, please call her/him to come to the doctor's office. I would like the doctor to talk to her/him and tell her/him what the matter is.

I would like to ask my mother/father what the doctor should do. I would like the doctor to do what my mother/father tells the doctor to do; she/he knows what is best for me.

Sometimes a doctor says that I need to have a shot or some other care. Sometimes a doctor says that I need to take pills or medicine. My mother father will also decide what other care I should have, but she/he will talk to me about what care I need.

I would also like my mother/father to decide if I need to go to the dentist.

If I am very sick, I might need to go to a hospital. My mother/father can decide if I need to go to the hospital. I would like all of the people at the hospital to speak with my mother/father about what the people at the hospital should do for me. I would like my mother/father to decide about my care at the hospital even if I am unable to understand what my doctor says about me. This is very important since I want the people at the hospital to try very hard to care for me if I am sick. If I need to have an operation because I am very sick, I would like the people at the hospital talk to my mother/father. My mother/father will say "yes" or "no" and that is what the people at the hospital will do.

I understand that I want my mother/father to help decide what care I need, and I want people to listen to him or her about my care. If my mother/father is not happy with my doctor, then he or she is able to get another doctor to care for me.

________________________________ ______________________
(Signature or Mark) (Date)

________________________________ ______________________
(Witness) (Date)

________________________________ ______________________
(Witness) (Date)

## DESIGNATION FOR DURABLE POWER OF ATTORNEY FOR MEDICAL TREATMENT, RESIDENTIAL PLACEMENT, AND PROGRAM DECISIONS

I am ________________________________ and I live at ________________________. I want my mother, _____________________________to help me if I am sick and need to see a doctor. I want her to make decisions about my medical care, including medication and surgery.

I also want my mother, __________________________ to make decisions about where I will live. She can sign any papers needed to arrange for a place for me to live.

I also want her to make decisions about work and other programs that I participate in.

If my mother, _____________________________ is not available, I would like my ___________________, _______________________________ to make these decisions instead.

If neither of the above are available, I would like my _________________________, ____________________________ to make these decisions.

I would like these powers to last even if I become unable to understand this form in the future. I understand that if I want to change my mind about who makes these decisions, I can destroy this paper or let people know I want to change my mind.

______________________ _______________________________________

(Date) (Signed)

STATEMENT OF WITNESSES

We sign below as witnesses. This was signed in our presence. The signer appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

Signed by witness: ________________________________

________________________________

(Print full name)

Signed by witness: ________________________________

________________________________

(Print full name)